FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022871

Facility Name: WEST CHICAGO TERRACE

Address: 928 JOLIET ROAD (Number) WEST CHICAGO (City) 60185 (Zip Code)

County: DU PAGE

Telephone Number: (847) PHONE **Fax #** (847) 674 - 5794

IDPA ID Number: 36-2883297

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	4,975	36,598	1	41,574	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,975	36,598	1	41,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 94.66%

D. How many bed-hold days during this year were paid by Public Aid? 1,413 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	133,157	8,292	5,960	147,409		147,409	0	147,409			1
2	Food Purchase		140,559		140,559		140,559	0	140,559			2
3	Housekeeping	107,784	9,599	0	117,383		117,383	0	117,383			3
4	Laundry	32,437	13,487	0	45,924		45,924	0	45,924			4
5	Heat and Other Utilities			65,216	65,216		65,216	76	65,292			5
6	Maintenance	58,002	22,892	16,702	97,596		97,596	2,175	99,771			6
7	Other (specify):*			8,110	8,110		8,110	0	8,110			7
8	**TOTAL General Services**	331,380	194,829	95,988	622,197		622,197	2,251	624,448			8
	B. Health Care and Programs											
9	Medical Director			0				0				9
10	Nursing and Medical Records	972,870	26,703	6,171	1,005,744		1,005,744	934	1,006,678			10
10a	Therapy	101,086		11,199	112,285		112,285	0	112,285			10a
11	Activities	59,610	4,537	2,200	66,347		66,347	0	66,347			11
12	Social Services	17,631		1,888	19,519		19,519	0	19,519			12
13	Nurse Aide Training			250	250		250	0	250			13
14	Program Transportation			0				0				14
15	Other (specify): DENTAL		1,650		1,650		1,650	0	1,650			15
16	**TOTAL Health Care and Progra**	1,151,197	32,890	21,708	1,205,795		1,205,795	934	1,206,729			16
	C. General Administration											
17	Administrative	69,349		355,766	425,115		425,115	(322,301)	102,814			17
18	Directors Fees			0				0				18
19	Professional Services			50,159	50,159		50,159	11,999	62,158			19
20	Dues, Fees, Subscriptions & Promotions			6,616	6,616		6,616	(707)	5,909			20
21	Clerical & General Office Expense	66,873	9,635	94,909	171,417		171,417	(56,137)	115,280			21
22	Employee Benefits & Payroll Taxes			178,149	178,149		178,149	0	178,149			22
23	Inservice Training & Education			1,246	1,246		1,246	61	1,307			23
24	Travel and Seminar			0				0				24
25	Other Admin. Staff Transportation			10,575	10,575		10,575	477	11,052			25
26	Insurance-Prop.Liab.Malpractice			44,679	44,679		44,679	1,141	45,820			26
27	Other (specify):*			0				7,053	7,053			27
28	**TOTAL General Administration**	136,222	9,635	742,099	887,956		887,956	(358,414)	529,542			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,618,799	237,354	859,795	2,715,948		2,715,948	(355,229)	2,360,719			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			77,974	77,974		77,974	291	78,265			30
31	Amortization of Pre-Op. & Org.			2,496	2,496		2,496	0	2,496			31
32	Interest			97,544	97,544		97,544	(6,754)	90,790			32
33	Real Estate Taxes			59,302	59,302		59,302	1,430	60,732			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			17,541	17,541		17,541	3,952	21,493			35
36	Other (specify):* IME			9,000	9,000		9,000	(9,000)				36
37	TOTAL Ownership			263,857	263,857		263,857	(10,081)	253,776			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			65,880	65,880		65,880		65,880			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,618,799	237,354	1,189,532	3,045,685	0	3,045,685	(365,310)	2,680,375			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(1,113)	30		9
10	Interest and Other Investment Income	(8,164)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(151)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(556)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(222)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(101)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,307)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(355,003)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (355,003)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (365,310)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS — **Page 5A**

Facility Name WEST CHICAGO TERRACE

IDP 0022871

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.				**Line 1**	0
1	**Day Care**	0	0	**Line 2**	0
2	**Other Care for Outpatients**	0	0	**Line 3**	0
3	**Governmental Sponsored Special Programs**	0	0	**Line 4**	0
4	**Non-Patient Meals**	0	2	**Line 5**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 6**	(10)
6	**Rented Facility Space**	0	34	**Line 7**	0
7	**Sale of Supplies to Non-Patients**	0	10	**Line 8**	(10)
8	**Laundry for Non-Patients**	0	4	**Line 9**	0
9	**Non-Straightline Depreciation**	(1,113)	30	**Line 10**	0
10	**Interest and Other Investment Income**	(8,164)	32	**Line 10a**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 11**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 12**	0
13	**Sales Tax**	0	2	**Line 13**	0
14	**Non-Care Related Interest**	0	32	**Line 14**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 15**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 16**	0
17	**Non-Care Related Fees**	0	20	**Line 17**	0
18	**Fines and Penalties**	0	21	**Line 18**	0
19	**Entertainment**	0	20	**Line 19**	0
20	**Contributions**	(151)	20	**Line 20**	(926)
21	**Owner or Key-Man Insurance**	0	22	**Line 21**	0
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 22**	0
23	**Malpractice Insurance for Individuals**	0	26	**Line 23**	0
24	**Bad Debt**	0	27	**Line 24**	0
25	**Fund Raising, Advertising and Promotional**	(556)	20	**Line 25**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 26**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 27**	0
28	**Yellow Page Advertising**	(222)	20	**Line 28**	(926)
29	**Non-Paid Workers**	0	0	**Line 29**	(1,848)
30	**Donated Goods**	0	0	**Line 30**	(1,113)
31	**Amortization Expense**	0	0	**Line 31**	0
52	DEFERRED MAINTENANCE	(101)	6	**Line 32**	(8,164)
				Line 33	0
				Line 34	0
				Line 35	0
				Line 36	0
				Line 37	(9,277)
				Line 38	0
				Line 39	0
				Line 40	0
				Line 41	0
				Line 42	0
				Line 43	0
				Line 44	0
				Line 45	(10,389)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	76	0	0	0	0	0	0	0	76	5
6	Maintenance	(101)	0	1,564	712	0	0	0	0	0	0	0	2,175	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(101)	0	1,564	788	0	0	0	0	0	0	0	2,251	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	934	0	0	0	0	0	0	0	0	934	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	934	0	0	0	0	0	0	0	0	934	16
	C. General Administration													
17	Administrative	0	(322,301)	0	0	0	0	0	0	0	0	0	(322,301)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	408	11,520	71	0	0	0	0	0	0	0	11,999	19
20	Fees, Subscriptions & Promotions	(929)	0	222	0	0	0	0	0	0	0	0	(707)	20
21	Clerical & General Office Expenses	0	5,720	(61,902)	45	0	0	0	0	0	0	0	(56,137)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	61	0	0	0	0	0	0	0	0	61	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	323	154	0	0	0	0	0	0	0	0	477	25
26	Insurance-Prop.Liab.Malpractice	0	300	774	67	0	0	0	0	0	0	0	1,141	26
27	Other (specify):*	0	2,297	4,756	0	0	0	0	0	0	0	0	7,053	27
28	**TOTAL General Administration**	(929)	(313,253)	(44,415)	183	0	0	0	0	0	0	0	(358,414)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,030)	(313,253)	(41,917)	971	0	0	0	0	0	0	0	(355,229)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,113)	198	460	746	0	0	0	0	0	0	0	291	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,164)	0	0	1,410	0	0	0	0	0	0	0	(6,754)	32
33	Real Estate Taxes	0	0	0	1,430	0	0	0	0	0	0	0	1,430	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,461	2,491	0	0	0	0	0	0	0	0	3,952	35
36	Other (specify):*	0	0	0	(9,000)	0	0	0	0	0	0	0	(9,000)	36
37	TOTAL Ownership	(9,277)	1,659	2,951	(5,414)	0	0	0	0	0	0	0	(10,081)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,307)	(311,594)	(38,966)	(4,443)	0	0	0	0	0	0	0	(365,310)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe WEST CHICAGO TERRACE # 0022871 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEME	LINCOLNWOOD	BOOKKEEPING
				EMI ENERPRISES	LINCOLNWOOD	MGMT CONSULTANT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
V	17	MANAGEMENT FEES	$ 324,766	EMI ENTERPRISES, INC		0	(324,766)	1	-334766
V								2	
V								3	
V	17	OFFICERS SALARY				12,465	12,465	4	12465
V	19	ACCOUNTING FEES				408	408	5	408
V	21	OFFICE EXPENSE				5,720	5,720	6	5720
V	25	TRANSPORTATION				323	323	7	323
V	26	INSURANCE				300	300	8	300
V	27	EMPLOYEE BENEFITS				2,297	2,297	9	2297
V	28	DEPRECIATION				198	198	10	198
V	35	AUTO LEASE				1,461	1,461	11	1461
V								12	
V								13	
Total			$ 324,766		0	$ 23,172	$ * (311,594)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	21	BOOKKEEPING FEES	$ 83,583	EKS MANAGEMENT, INC.		$	$ (83,583)	15	-83583
16	V								16	
17	V								17	
18	V	6	PAINTING SALARIES				1,564	1,564	18	1564
19	V	10	RN CONSULTANT SALARIES				934	934	19	934
20	V	19	PROFESSIONAL FEES				11,520	11,520	20	11520
21	V	20	WANT ADS				222	222	21	222
22	V	21	OFFICE EXPENSE				21,681	21,681	22	21681
23	V	23	SEMINARS				61	61	23	61
24	V	25	TRANSPORTATION				154	154	24	154
25	V	26	INSURANCE				774	774	25	774
26	V	27	EMPLOYEE BENEFITS				4,756	4,756	26	4756
27	V	30	DEPRECIATION				460	460	27	460
28	V	35	EQUIPMENT RENT				2,491	2,491	28	2491
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 83,583			$ 44,617	$ * (38,966)	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	36	OFFICE RENT	$ 9,000	IME REALTY CORP.		$	$ (9,000)	15	-9000
16	V								16	
17	V								17	
18	V	5	UTILITIES				76	76	18	76
19	V	6	REPAIRS & MAINTENANCE				712	712	19	712
20	V	19	PROFESSIONAL FEES				71	71	20	71
21	V	21	OFFICE EXPENSE				45	45	21	45
22	V	26	INSURANCE				67	67	22	67
23	V	30	DEPRECIATION				746	746	23	746
24	V	32	INTEREST				1,410	1,410	24	1410
25	V	33	RE TAX				1,430	1,430	25	1430
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 9,000			$ 4,557	$ * (4,443)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	BERNARD COHEN	GENERAL PART	ADMINISTRATION		SEE ATTACHED SCHEDULE			MGMT FE	$ 21,000	17-3	1
2	MORRIS ESFORMES	GENERAL PART	ADMINISTRATION					SALARY	12,465	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,465		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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the name(s)
PORTS.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT C... Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: EMI ENTERPRISES
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	617,052	11	$ 185,000	$ 185,000	41,574	$ 12,465	1
2	19	ACCOUNTING FEES	PATIENT DAYS	617,052	11	6,053		41,574	408	2
3	21	OFFICE EXPENSE	PATIENT DAYS	617,052	11	84,917	64,123	41,574	5,720	3
4	25	TRANSPORTATION	PATIENT DAYS	617,052	11	4,810		41,574	323	4
5	26	INSURANCE	PATIENT DAYS	617,052	11	4,462		41,574	300	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	617,052	11	34,099		41,574	2,297	6
7	30	DEPRECIATION	PATIENT DAYS	617,052	11	2,964		41,574	198	7
8	35	AUTO LEASE	PATIENT DAYS	617,052	11	21,677		41,574	1,461	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 343,982	$ 249,123		$ 23,172	25

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STATE OF ILLINOIS

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: EKS MGMT,
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING SALARIES	PATIENT DAYS	617,052	11	$ 23,229	$ 23,229	41,574	$ 1,564	1
2	10	RN CONSULTANT SALARI	PATIENT DAYS	617,052	11	13,856	13,856	41,574	934	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	617,052	11	170,994	131,341	41,574	11,520	3
4	20	WANT ADS	PATIENT DAYS	617,052	11	3,290		41,574	222	4
5	21	OFFICE EXPENSE	PATIENT DAYS	617,052	11	321,801	269,147	41,574	21,681	5
6	23	SEMINARS	PATIENT DAYS	617,052	11	905		41,574	61	6
7	25	TRANSPORTATION	PATIENT DAYS	617,052	11	2,302		41,574	154	7
8	26	INSURANCE	PATIENT DAYS	617,052	11	11,476		41,574	774	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	617,052	11	70,589		41,574	4,756	9
10	30	DEPRECIATION	PATIENT DAYS	617,052	11	6,797		41,574	460	10
11	35	EQUIPMENT RENT	PATIENT DAYS	617,052	11	36,988		41,574	2,491	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 662,227	$ 437,573		$ 44,617	25

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STATE OF ILLINOIS

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: IME REALTY CORP.
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	100	11	$ 1,685	$	4	$ 76	1
2	6	REPAIRS & MAINTENANC	INCOME	100	11	15,902		4	712	2
3	19	PROFESSIONAL FEES	INCOME	100	11	1,575		4	71	3
4	21	OFFICE EXPENSE	INCOME	100	11	1,047		4	45	4
5	26	INSURANCE	INCOME	100	11	1,504		4	67	5
6	30	DEPRECIATION	INCOME	100	11	16,647		4	746	6
7	32	INTEREST	INCOME	100	11	31,549		4	1,410	7
8	33	RE TAX	INCOME	100	11	32,000		4	1,430	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 101,909	$		$ 4,557	25

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STATE OF ILLINOIS

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SOUTH TRUST		X	MORTGAGE		08/01/95	$ 1,390,000	$ 1,161,738	07/13/15		$ 78,288	1
2	SOUTH TRUST		X	LETTER OF CREDIT							18,493	2
3												3
4												4
5												5
	Working Capital											
6			X	INSURANCE FINANCING							763	6
7												7
8	RELATED PARTY	X									1,410	8
9	TOTAL Facility Related						$ 1,390,000	$ 1,161,738			$ 98,954	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,390,000	$ 1,161,738			$ 98,954	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	62,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	60,602	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,898)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	61,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	59,302	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	56,354	8
	1996	56,626	9
	1997	60,461	10
	1998	61,858	11
	1999	60,602	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,898 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1973	$ 1,233,000	$ 49,320	25	$ 49,320	$	$ 1,220,670	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	BUILDING IMPROVEMENT			8183	34,112					34,112	9
10	BUILDING IMPROVEMENT			1987	17,555	557	20	557		7,313	10
11	BUILDING IMPROVEMENT			1988	51,503	1,635	31.5	1,635		21,187	11
12	BUILDING IMPROVEMENT			1990	4,140	131	31.5	131		1,337	12
13	BUILDING IMPROVEMENT			1992	23,333	741	31.5	741		6,131	13
14	BUILDING IMPROVEMENT			1993	22,204	610	31.5	610		4,635	14
15	BUILDING IMPROVEMENT			1994	74,985	1,923	39	1,923		13,050	15
16	TILE			1996	2,547	65	39	65		312	16
17	ROOFTOP COMPRESSOR			1998	1,653	42	39	42		103	17
18	FIRE BACKFLOW DEVICE			1998	7,245	186	39	186		380	18
19	DOORS			1999	2,734	70	39	70		126	19
20	SIGNS			1999	968	65	15	65		97	20
21	ELECTRICAL WORK			1999	8,138	209	39	209		340	21
22	CARPET, TILE, COVE BASE			2000	20,242	2,893	20	506	(2,387)	506	22
23	CUBICLE CURTAINS, DRAPES			2000	12,817	1,831	20	320	(1,511)	320	23
24	ROOF			2000	9,850	164	27.5	164		164	24
25	ASBESTOS ABATEMENT			2000	4,193	108	27.5	108		108	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 60,550		$ 56,652	$ (3,898)	$ 1,310,891	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 195,587	$ 15,559	$ 19,556	$ 3,997	10 YRS	$ 132,433	37
38	Current Year Purchases	13,051	1,865	653	(1,212)	10 YRS	653	38
39	Fully Depreciated Assets	248,394					248,394	39
40	RELATED PARTY		1,404	1,404				40
41	TOTALS	$ 457,032	$ 18,828	$ 21,613	$ 2,785		$ 381,480	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 79,378	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 78,265	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (1,113)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,692,371	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
   This amount was calculated by dividing the total amount to be amortized _____
   by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning _____
    Ending _____

11. Rent to be paid in future years under the curre
    rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 8,249 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT, NURS, ACT	99 FORD VAN	$ 499.00	$ 6,086	17
18	SMART LEASE	GMAC	401.00	3,206	18
19					19
20					20
21	TOTAL		$ 900.00	$ 9,292	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 147,750	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,000)	709,025		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,489		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	406,047		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,337,311	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	298,219		15
16	Equipment, at Historical Cost	457,033		16
17	Accumulated Depreciation (book methods)	(1,729,550)		17
18	Deferred Charges	36,355		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 395,057	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,732,368	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,419	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,317		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,070		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 242,006	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,161,738		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,161,738	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,403,744	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 328,624	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,732,368	$	48

***(See instructions.)**

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Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 919	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 919	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	746,231	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(418,526)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 327,705	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 328,624	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,783,752	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,783,752	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,164	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 8,164	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 3,791,916	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 622,197	31
32	Health Care	1,205,795	32
33	General Administration	887,956	33
	B. Capital Expense		
34	Ownership	263,857	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,045,685	40
41	**Income before Income Taxes (line 30 minus line 40)****	746,231	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 746,231	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,678	1,798	$ 46,588	$ 25.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,603	12,481	243,214	19.49	3
4	Licensed Practical Nurses	4,217	4,432	76,308	17.22	4
5	Nurse Aides & Orderlies	52,289	56,712	553,148	9.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,531	10,236	101,086	9.88	8
9	Activity Director					9
10	Activity Assistants	6,397	6,572	59,610	9.07	10
11	Social Service Workers	1,524	1,732	17,631	10.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,217	16,257	133,157	8.19	15
16	Dishwashers					16
17	Maintenance Workers	4,721	4,793	58,002	12.10	17
18	Housekeepers	13,574	14,565	107,784	7.40	18
19	Laundry	4,353	4,672	32,437	6.94	19
20	Administrator	2,080	2,176	69,349	31.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,642	7,107	66,873	9.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,047	2,103	34,269	16.30	31
32	Other Health Care(specify)					32
33	Other(specify QUAL ASSR	2,080	2,080	19,343	9.30	33
34	TOTAL (lines 1 - 33)	137,953	147,716	$ 1,618,799 *	$ 10.96	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,960	1-3	35
36	Medical Director		0	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		4,790	10-3	39
40	Physical Therapy Consultant		3,875	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		2,200	11-3	44
45	Social Service Consultant		1,638	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 18,463		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides	24	281	10-3	52
53	TOTAL (lines 50 - 52)	24	$ 281		53

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ZACHERY CAULKINS	ADMIN		$ 69,349
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,349

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 334,766
BERNARD COHEN	21,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 355,766
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SYSTEMS	DATA PROCESSING	$ 3,537
ALPHA CPX	DATA PROCESSING	55
INTEGRATED INVENTORY	DATA PROCESSING	1,250
NURSING CARE SYSTEMS	DATA PROCESSING	5,458
SOURCETECH	DATA PROCESSING	178
MID AMERICA	DATA PROCESSING	1,320
MAXSOURCE	DATA PROCESSING	250
KBKB	ACCOUNTING	11,100
LAWRENCE SCHWARTZ	LEGAL	18,000
MC BRIDE	LEGAL	6,551
PERSONNEL PLANNERS	UC CONSULTANT	370
LINCOLNWOOD REMARKET	REMARKETING FEE	2,090
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 50,159

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,045
Unemployment Compensation Insurance	11,004
FICA Taxes	123,839
Employee Health Insurance	8,961
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	300
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 178,149

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,688
Health Care Worker Background Chec	250
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	778
DUES & SUBSCRIPTIONS	3,221
LICENSES & PERMITS	528
TRUST FEES, CONTRIBUTIONS,etc.	151
MGMT CO ALLOCATION	222
LESS TRUST FEES, CONTRIB, etc.	(151)
Less: Public Relations Expense	( )
Non-allowable advertising	(556)
Yellow page advertising	(222)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,909

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	0
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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